DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/23/16 70th 11/17/16

PRINTED: 09/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445143	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT ROCKWOOD, THE	5580 ROANE STATE HWY ROCKWOOD, TN 37854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 047 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain exit signs. The findings include: Observation and interview with the maintenance director on 9/6/16 between 9:00 and 10:30 AM revealed the exit signs were not illuminated by rooms 201, 358, 220, and at the physical therapy exit. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 9/6/16.	K 047	**K 047 NFPA 101 LIFE SAFETY CODE STANDARD** **SS=F** 1.) On 9/8/16 exit signs were ordered to replace exit signs that did not have adequate illumination. On 9/14/16 exit signs were replaced. 2.) On 9/8/16 100% of exit signs were audited for adequate illumination 2 others were found with dim illumination and replaced. Plant Ops Department ordered enough to replace the dim lights and have extra on stock. 3.) Starting 9/8/16 Facility Plant Ops Director and/or Plant Ops assistant will audit exit signs weekly for 6 weeks for correct illumination. After 6 weeks Plant Ops department will monitor exit signs quarterly for correct illumination. 4.) Starting 9/28/16 findings of exit sign audits will be reported to QAPI monthly for 3 months.	9/30/16
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain the automatic sprinkler system. The findings include: Observation, record review and interview with the maintenance director on 9/6/16 between 9:00 AM	K 062	**K 062 NFPA 101 LIFE SAFETY CODE STANDARD** **SS=F**	9/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determinsd that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LR0821 TN 7302

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K 062	Continued From page 1 and 10:30 AM revealed; 1. There was no signage at the FDC. 2. *need 2 inspectors test signs. 3. *need 4 air/water gauges. 4. There was no 5 year obstruction investigation. *taken from 6/16 quarterly inspection report. NFPA 25, 9-7.1 & 10-2.2 These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 9/6/16.	K 062	1.) On 9/15/16 FDC signage was posted. On 9/15/16 Inspector Test signs were posted. On 9/15/16 4 air/water gauges were replaced. On 9/8/16 5 year obstruction test confirmation paper was received and logged and up to date. 2.) On 9/15/16 Plant Ops Director and Plant Ops assistant walked through facility to ensure no other signage was needed as required. No other signage was found to be needed.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.	K 066	3.) On 9/15/16 education was provided to Facility Plant Ops Director and Plant Ops assistant on FDC signage, Inspector Test signs, air/water gauges, and obstruction test by a CEO. Starting 9/16/16 Plant Ops Department will start audits to ensure signage is posted, gauges are in place and obstruction test is completed and up to date. 4.) Starting 9/28/16 findings will be reported to QAPI monthly for 3 months. **K 066 NFPA 101 LIFE SAFETY CODE STANDARD** SS=D	9/30/16
	(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by:		1.) On 9/8/16 metal self-closing container was placed in smoking area by Plant Ops Department.	

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K 066	Continued From page 2 Based on observation and interview, the facility failed to maintain smoking area. The finding includes: Observation and interview with the maintenance director on 9/6/16 at 10:27 AM revealed there was no metal container with a self-closing lid in the employee smoking area. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 9/6/16.	K 066	2.) On 9/8/16 Plant Ops Director and Plant Ops assistant walked through other smoking areas around the facility to ensure each had a metal self-close lid. No more were determined to be needed. 3.) On 9/23/16 education was provided to Plant Ops Department on smoking regulations by CEO. Starting on 9/16/16 Plant Ops Department will audit all smoking areas weekly for 6 weeks to ensure they have a metal self-closing receptacle.	9/30/16
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire doors. The findings include: Observation and interview with the maintenance director on 9/6/16 between 9:45 and 12:41 AM revealed; 1. The pantry door in dietary failed to close and latch. 2. Cross-corridor doors by room 131 failed to latch to the floor. 3. There were no floor strikes for the fire doors by room 210. ~~NFPA 101, 8.2.3.2.1 & NFPA 80, 10-1.2~~ These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 9/6/16.	K 130	4.) Staring 9/28/16 audit findings will be reported to QAPI monthly for 3 months. **K 130 NFPA 101 MISCELLANEOUS** **SS=E** 1.) On 9/23/16 pantry door in dietary was repaired. On 9/20/16 cross-corridor doors by room 131 was assessed and parts ordered for repair by 9/30/16. On 9/8/16 floor strikes were added to fire doors by room 210.	

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Division of Health Care Facilities

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	TN7302	A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	09/06/2016

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N 002	1200-8-6 No Deficiencies During the life safety portion of the survey conducted on 9/6/16, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002	2.) On 9/8/16 all doors in facility were audited and repairs made as needed. 3.) Starting 9/16/16 Plant Ops Department will audit facility doors weekly for 6 weeks. 4.) Starting 9/28/16 audit findings will be reported to QAPI monthly for 3 months.	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE